	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S	URVEY
		445302	B. WING		03/2	1/2012
LIFE CAI	ROVIDER OR SUPPLIER RECENTER OF ELIZA	ABETHTON	11	EET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		172012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
\$S=D	A facility must immer consult with the resistance, notify the resistance and interested farmaccident involving the injury and has the printervention; a significantly and has the printervention; a significantly in the earliest complication significantly (i.e., a nexisting form of treatment); or a decitate resident from the §483.12(a).  The facility must also and, if known, the reor interested family resident rights under regulations as specified in §483.15 regulations as specification.  The facility must receive address and photegal representative of this REQUIREMENTOY: Based on medical regulations as specifications and photegal representative of this REQUIREMENTOY:	FY OF CHANGES (ROOM, ETC)  Ediately inform the resident; dent's physician; and if sident's legal representative illy member when there is an ite resident which results in obtential for requiring physician icant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial preatening conditions or s); a need to alter treatment need to discontinue an itement due to adverse a commence a new form of sion to transfer or discharge a facility as specified in a promptly notify the resident sident's legal representative number when there is a pommate assignment as (e)(2); or a change in Federal or State law or ited in paragraph (b)(1) of ord and periodically update ne number of the resident's or interested family member.  If is not met as evidenced accord review and interview, offly the physician of a		For those residents found to have affected by the deficient practice:  a) On 03/19/12, the charge nurs resident #12's physician of the charge in condition, and Vic's was ordered.  b) Charge Nurse was educated by development coordinator on the charge in condition.  How you will identify other reside the potential to be affected by the deficient practice and what correct will be taken:  a) All facility residents have the be affected by this practice.  b) On 3/20/12, all residents were nursing administration for charge deficient and for appropriate; notification. All residents were appropriately.  What measures will be put into playstematic changes you will make the deficient practice does not 1) On 03/20/12, the staff develop coordinator initiated education licensed nurses on the facility' procedure for "Notification of Status".  1) On 04/18/12 and on 04/20/12, will be educated on the facility "Notification of Changes in Status".	e notified te resident's 's Vapor Rub by the staff 03/19/12 on tident's  ents having same tive action  potential to assessed by assessed by assessed by assessed by assessed by assessed to ensure recur: ment to ensure recur: ment with s policy and Changes in all nurses 's atus" atus" will tion packet	5/5/1

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other/safeguards provide sufficient protestion to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event (D; EY8Z11

Facility ID: TN1004

If continuation sheet Page 1 of 16

STATEMEN	T OF DEFICIENCIES				OMB NO	. 0830-0391	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445302	B. Wie	NG_		03/2	1/2012
NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF ELIZA	ABETHTON		1	641 HIGHWAY 19E ELIZABETHTON, TN 37643		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	l ID		PROVIDER'S PLAN OF CORRECT	TICAL	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF YAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 1	F-	157	How the corrective actions will be	monitored	-/-/30
	change in condition	for one resident (#12) of			to ensure the deficient practice will	not recur;	5/5/12
	twenty-five resident	s reviewed,			i.e., what quality assurance program will bout into place:		
	The findings include	ed:			, <u> </u>		
					a) The director of nursing, assista	nt director	
Resident #12 was		admitted to the facility on			of nursing, and/or the nursing s will audit the 24hr report daily	npervisor	
	of Pulmonany Embo	th diagnoses including History lism, Edema, Depressive			report from the charge nurses t	O WEIGHT	· }
	Disorder, and Anxie	tv State			proper procedures, intervention	ı, and	
		y otale.			actions were initiated and/or co	mpleted.	
Medical record rev		iew of the resident Minimum			b) The director of nursing and/or	assistant	
	Data Set (MDS) dat	ed December 19, 2011,			director of nursing will report t	he findings	į
		rview for Mental Status			of the notification of change of audits to the executive director	status	
	(DIMS) Score of four	rteen which indicates a			daily morning meeting, and to	.р.» antniā	
	the MDS revealed the	sident. Continued review of ne resident was always			performance improvement com	mittee for	
	uлderstood and alw	avs understands		-	3 months.		' [
		ayo angolowinga.		Ì	c) The performance improvement	committee	ŀ
	Observation and inte	erview on March 19, 2012, at			will review the results; and if de	æmed	
	10:22 a.m., in the re	sident's room, revealed the		1	necessary by the committee, ad-	ditional	
	resident sitting on th	e bed. Continued observation		j	education may be provided. The may be evaluated/revised and/o	c process	}
	connection and had	ed the resident with audible requested vapor rub	-		reviewed for 3 months or until 1	r the audits	i
	(medication for con-	estion) on March 18, 2012,			compliance is achieved.	.0070	
	from Licensed Pract	ical Nurse (LPN) #5.		1	d) Performance improvement com	mittee	
		,			members are the executive direct	tor, the	
ı		sident and LPN #2 on March			medical director, the director of	nursing,	
		n., in the resident's room,			the assistant director of nursing,	the MDS	
ĺ	confirmed the Physic	cian had not been informed of			coordinator, the PPS nurse, the services manager, the social services	enab	ľ
E 246	the congestion or rec	quest of medication.			director, the dietary manager, th	/ICES	1
S\$=D	OF NEEDS/PREFER	NABLE ACCOMMODATION			pharmacist, the maintenance dire		
30-0	AL MEDOQUENERE!	, I			business office manager, the	-	
	A resident has the ric	ght to reside and receive			housekeeping supervisor, the sta	.ff	-
	services in the facility	y with reasonable			development coordinator, and th	e wound	İ
	accommodations of	individual needs and			care nurse.		
	preferences, except	when the health or safety of					]
	the individual or othe	r residents would be					j

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Event ID: EY8Z11

Facility ID: TN1004

If continuation sheet Page 2 of 16

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

D (2.111 pm)	10 I OIL MEDIONICE	W MEDIONID OF CHOCK					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		445302	B. Wil	₩Ģ		03/2	1/2012
NAME OF P	RÖVIDER OR SUPPLIER	·-			EET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAI	RE CENTER OF ELIZA	ABETHTON		1641 HIGHWAY 19E ELIZABETHTON, TN 37643			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 246	Continued From pa endangered.	ge 2	F	246	What corrective actions will be a For those residents found to have affected by the deficient practice:  a) On 03/19/12, the housekeepi moved resident #13 and # 14 allow for the residents to mo	been ng manager 's beds to	5/5/12
	by: Based on medical and interview, the fa rooms where arran	NT is not met as evidenced record review, observation, acility failed to ensure resident ged to accommodate the ents (#13 & #14) of twenty-five			freely in their rooms, and the were updated.  b) On 03/19/12, the executive deducated the housekeeping neassuring that each resident has appropriate square footage wassuring that residents are abfreely in their rooms.	ir care plans irector ianager on is the hile also	
	September 15, 200 Abnormality of Gait Muscle Weakness.  Medical record revi Data Set (MDS) da revealed "Locomo	admitted to the facility on 8, with diagnoses including , Diabetes Mellitus, and			How you will identify other resid the potential to be affected by the deficient practice and what correc will be taken: a) All facility residents have the be affected by this practice. b) On 3/19/12, the housekeepin audited all resident rooms. A rooms were arranged to prov accommodation of each indiv resident's needs.	same tive action  potential to g manager Il resident de for the	
	2012, at 10:50 a.m. in a wheelchair. Co time revealed the rewheelchair and unathe resident's room  Interview with resident's a.m., reveale get to the other side the bed arrangeme.	resident's room on March 19, revealed resident #13 sitting ntinued observation at this esident was mobile in a able to get to the other side of due to a bed blocking access.  ent #13 on March 19, 2012, at at the resident was unable to a of the room and did not like nt.  19, 2012, at 1:48 p.m., with Manager revealed the		•	What measures will be put into pleasystematic changes you will make that the deficient practice does not a) On 03/19/12, the housekeeping educated all housekeepers on each resident has the appropriate footage while also assuring the are able to move freely in the b) On 04/18/12 and on 04/20/12 will be educated by the facility director to assure that everyout understands the importance of resident rooms are accommodificable to residents.	to ensure t recur: g manager assuring that inte square nat residents ir rooms. , all staff y executive ne f assuring	

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Event ID: EY8Z11

Facility ID: TN1004

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CENIE	O FUR MEDICARE	& MEDICAID SEKVICES	,			CIVID NO.	0930-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445302	B. WING	G		03/2	1/2012
NAME OF P	ROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , , ,			EET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF ELIZA	ABETHTON			41 HIGHWAY 19E JIZABETHTON, TN 37643		
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFiX YAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	Resident #14 was a March 31, 2008, with Anxiety, Hypertensia. Observation in the 12012, at 10:34 a.m. ambulating in a whathe other side of the the resident's move Interview with the resident's move Interview with the resident's bed had Interview with the Assistant (CNA) #1 a.m., in the resident resident was able to when the bed did not Interview with the A 2012, at 3:20 p.m., confirmed the facility furniture was arrang accommodation of #14.  483.20(k)(3)(i) SER PROFESSIONAL STHE SERVICES provide must meet professional must meet professional interview, and reviewed.	deen recently moved.  Indiritted to the facility on the diagnoses including on, and Esophageal Reflux.  The sident's room on March 19, revealed resident #14 self electrain and unable to get to erroom due to a bed blocking ement.  The sident and Certified Nursing on March 19, 2012, at 10:36 the room, revealed the even recently moved. The transport of the end of	F 2		c) The housekeeping manager were resident rooms for resident accommodations weekly for fand monthly for 2 months.  How the corrective actions will be to ensure the deficient practice will i.e., what quality assurance programput into place:  a) The housekeeping manager wiresults of the room audits to the performance committee for 3 results of the results; and if decessary by the committee, acceducation may be provided. The may be evaluated/revised and/or reviewed for 3 months or until compliance is achieved.  c) Performance improvement commembers are the executive director of the assistant director, the director of the assistant director of nursing coordinator, the PPS nurse, the services manager, the social sedirector, the dietary manager, the housekeeping supervisor, the statevelopment coordinator, and to care nurse.	monitored not recur, n will be  Il report the committee committee ditional he process or the audits 100%  muittee cotor, the f nursing, t, the MDS rehab rvices he rector, the	5/5/12
		w or racility policy and ty failed to follow a physician's					

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Event ID: EY8Z11

Facility ID: TN1004

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
445302 6. WING	03/21/2012
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ELIZABETHTON  STREET ADDRESS, CITY, STATE 1641 HIGHWAY 19E  ELIZABETHTON, TN 37	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)  (X5) COMPLETION DATE
F 281 Continued From page 4 order for two residents (#4 & #12) of twenty-five residents reviewed.  The findings Included: Resident #4 was admitted to the facility on March 18, 2012, with a diagnosis of a Total Right Hip Replacement.  Observation on March 19, 2012, at 10:55 a.m., in the resident's room, revealed an IV (intravenous) device that was capped off for future use. Further observation revealed a date of March 15, 2012, on the IV dressing site.  Medical record review of a physician's order, dated March 9, 2012, revealed "change INT (peripheral IV) site/drsg (dressing) every 72 hr/pm (hours and as needed)"  Review of the facility's policy "intravenous thanged aseptically every 48-72 hours at peripheral sites"  Observation and interview with LPN #7, at 11:00 a.m., on March 19, 2012, in the resident's room, confirmed the date on the IV site was March 15, 2012. Further interview confirmed the dressing had not been changed within 72 hours and the facility failed to follow the physician's order.  What measures will be systematic changes we that the deficient practice and on the facility policy and proced development coordinate to be on 03/22/12, and the deficient practice and will he taken:  a) All facility reside be affected by the binary of the potential to be affected by the binary of the deficient practice and will be response to the facility policy intravenous administration. No found.  What measures will be systematic changes we that the deficient practice and on the facility policy and proced development coordinates.  F 281  For those residents for on Arich 15, 2012, respectively the deficient practice and will be facility policy and proced development coordinates.  How you will identify the potential to be affected by the binary of the potential to be affected by the deficient practice and will be the potential to be affected by the deficient practice and will be respectively.	ent practice: Ident #4's dressing was harge nurse. Ident #12 received the from the charge nurse. Ident #12 received on Ident #12 rec

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: EY6Z11

Facility ID: TN1004

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
			A. BU	ЩПИ	<b>G</b>		
		445302	8, W/	VG	· · · · · · · · · · · · · · · · · · ·	03/21	/2012
	ROVIDER OR SUPPLIER RE CENTER OF ELIZA	ABETHTON		10	REET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	of Pulmonary Embor Disorder, and Anxie Medical record revidated March 19, 20 "ApplyVapor Ruchest congestion"  Interview with the resident as a March 19, 2012.  Interview with the Limarch 20, 2012, at confirmed the medication as a confirmed the medication as a confirmed the medical pharmacy evening; had not be resident; and the place of the place	plism, Edema, Depressive ety State.  ew of a Physician's order 12, at 4:00 p.m., revealed 15 as directed as neededfor  esident on March 20, 2012, at 1 the resident had not received equested on March 18, and  icensed Practical Nurse #7 on 8:45 a.m., on the 300 hall, ication was obtained from the yesterday (March 19, 2012) een given as requested by the hysician's order had not been	F	281	c) Nursing administration will aud MARS/TARS and resident recompare physician notification, will be completed weekly for for and monthly for 2 months.  How the corrective actions will be to ensure the deficient practice will i.e., what quality assurance program put into place:  a) The director of nursing and/or a director of nursing will report to of the record reviews to the perimprovement committee for the The performance improvement will review the results; and if do necessary by the committee, adeducation may be provided. The may be evaluated/revised and/or reviewed for 3 months or until compliance is achieved.  c) Performance improvement commembers are the executive director of the assistant director, the director of the assistant director of nursing coordinator, the PPS nurse, the services manager, the social ser director, the distary manager, the pharmacist, the maintenance director, the distary manager, the housekeeping supervisor, the start development coordinator, and the care nurse.	monitored not recur; will be assistant the results formance ee months. committee extend ditional as process or the audits 100% mittee etor, the foursing, the MDS rehab vices as exector, the aff	5/5/12
	by: Based on medical and interview, the f	NT is not met as evidenced record review, observation, facility failed to ensure fails place for one resident (#17) ents reviewed.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY YED
	'	445302	B. WII	NG		03/2	1/2012
	ROVIDER OR SUPPLIER RE CENTER OF ELIZ	ABETHTON		11	EET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 323	November 2, 2009 Psychosis, Failure to Difficulty Walking, It Ischemic Heart Distriction of the Minim February 6, 2012, reseverely cognitively extensive assistant toileting.  Observation on Marke resident's room, the bed, the bed in rails up and no falls Medical record reviewealed the resident 23, 2012, and Marce Further review of the 23, 2012, revealed Medical record reviewed at the deside". Finvestigation report, revealed "floor market in the resident's roow was not at the resident's room was not at the resident's	admitted to the facility on with diagnoses including or Thrive, Muscle Weakness, Dementia, Hypertension, ease and Esophageal Reflux.  Inum Data Set (MDS), dated evealed the resident was impaired and required e with transfer, bathing and revealed the resident lying in the lowest position, two side mat on the floor.  Ew of the nurse's notes and suffered a fall on February in 5, 2012, (with no injuries).  E Care Plan, dated February infloor mat at bedside"  Ew of a physician's order, 2012, revealed "add floor further review of the facility's dated March 5, 2012,	F	323	What corrective actions will be accepted by the deficient practice:  a) On 03/21/12, resident #17's fare placed at bedside by the central clerk.  b) On 03/21/12, the charge nurse certified nursing assistants were serviced on proper review of the care guide to ensure that fall practice in place by the staff develous coordinator.  How you will identify other resident the potential to be affected by the stafficient practice and what correctively be taken:  a) Residents with fall precautions potential to be affected by these by On 03/21/12, all residents with ordered fall interventions were appropriate placement by nursification. All intervention found to be in place.  What measures will be put into place systematic changes you will make that the deficient practice does not read on 03/21/12, licensed nurses an nursing assistants were educate staff development coordinator of importance of reviewing the resignides to ensure resident's fall interventions are in place.  b) On 04/18/12 and on 04/20/12, a will be in-serviced by the staff development coordinator on the importance of ensuring that resident practice and the importance of the suring that resident practices and the importance of the suring that resident practices and the importance of the suring that resident practices and the importance of the suring that resident practices and the importance of the suring that resident practices and the importance of the suring that resident practices and the suring that resident practices and the suring that resident practices and the suring that resident practices are suring that resident practices and the suring that resident practices are suring that the suring practices are s	and re in- he resident recautions pment  that having ame we action have the epractices. physician audited for ing ms were  the or what or ensure ecur: and certified d by the on the sident care  that staff ident's fall he	5/5/12

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Facility ID: TN1004

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	!	445302	B. WI	IG_		03/2	1/2012
	ROVIDER OR SUPPLIER RE CENTER OF ELIZ	ABETHTON		10	REET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUSY BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323 F 431 SS≃E	resident. 483.60(b), (d), (e) E LABEL/STORE DR  The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is a reconciled.  Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartmer controls, and perminave access to the  The facility must propermanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distri	PRUG RECORDS, UGS & BIOLOGICALS  Inploy or obtain the services of elist who establishes a system of and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically  als used in the facility must be ce with currently accepted les, and include the ory and cautionary expiration date when  State and Federal laws, the II drugs and biologicals in its under proper temperature to only authorized personnel to keys.  Divide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit button systems in which the inimal and a missing dose can	F;		c) Nursing administration will audresidents with falls intervention they are in place weekly for for and monthly for 2 months.  How the corrective actions will be to ensure the deficient practice will i.e., what quality assurance program put into place:  a) The director of nursing and/or a director of nursing will report to of the resident's fall intervention the performance improvement will review the results; and if denecessary by the committee, addeducation may be provided. The may be evaluated/revised and/or reviewed for 3 months or until compliance is achieved. c) Performance improvement commembers are the executive direct medical director, the director of the assistant director of nursing, coordinator, the PPS nurse, the services manager, the social serdirector, the dietary manager, the housekeeping supervisor, the stadevelopment coordinator, and the care nurse.	monitored not recur; a will be assistant the results a sudits to committee committee committee and the process of the audits 100% and the mursing, the MDS rehabovices are cor, the aff	5/5/12

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Event JD: EY8Z11

Facility ID: TN1004

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445302	B. WII	√G,		03/2	1/2012
	PROVIDER OR SUPPLIER	ABETHTON		1	REET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		į
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	This REQUIREMENT by: Based on observative review of Tennesse Edition, and interviet the contents of emeresidents in three (Nemergency Box CE Blue Intravenous [Nemergency Box CE B	ion, review of facility's policy, se Pharmacy Laws 2011 why, the facility failed to secure ergency medications for North Hall First Dose Orange 61, North Hall First Dose Orange Emergency Box, irst Dose Orange Emergency boxes observed in lication Room, South/West from) of two medication rooms of the provide documentation of the for control substances of absence for one (#21) of a residents reviewed.  First Dose Orange Emergency and the second of the box was observation of the list of side of the box revealed 906 tions requiring physician for lood pressure			What corrective actions will be accorded for those residents found to have be affected by the deficient practice:  a) No residents were affected by the deficient practice.  b) On 03/20/12, all emergency box locked and the contents were set the charge nurses.  c) On 03/21/12, licensed practical was educated by the director of the importance of ensuring the of Responsibility for Medication completed at the time of a reside of absence from the facility.  How you will identify other resident the potential to be affected by the said deficient practice and what corrective will be taken:  a) Residents needing medications a leave of absence from the facility potential to be affected by this dipractice.  b) On 03/20/12, all residents' recontake a leave of absence from the were reviewed for "Release of Responsibility for Medication" to compliance. All other resident revere complete.  c) On 03/20/12, the charge nurses all emergency boxes to ensure the locked and secure. All emergency were found to be locked and secure.	ten  tis  ties were cured by  murse #3 mursing on 'Release th' form is ent's leave  s having me e action while on y have the efficient ds that facility  form ecords eviewed tey were cy boxes	5/5/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445302	B. WING		03/2	1/2012
	ROVIDER OR SUPPLIER RECENTER OF ELIZ	ABETHTON TEMENT OF DEFICIENCIES	<u>,                                    </u>	TREET ADDRESS, CITY, STATE, ZIP CO 1641 HIGHWAY 19E ELIZABETHTON, TN 37643 PROVIDER'S PLAN OF CO	DE	
PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	Box" revealed, "S for emergency care emergency drug both Review of the Tenn Edition Rule 1140-4 HOME CARE KITS (3) The emergency or electronically section accordance with Interview with LPN: 10:55 a.m., in the Note confirmed the emerthe contents were in the Administrator's boxes are to be sectionally to be sectionally to both Hall Medication of the IBox on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box on March 19, 2 North Hall Medication of the Box of the Facility Box" revealed, "S for emergency drug box of the Facility Box" revealed, "S for emergency drug box of the Box of the Box" revealed, "S for emergency drug box of the Box of the Box" revealed, "S for emergency drug box of the Box of the Box" revealed, "S for emergency drug box of the Box of the Box" revealed, "S for emergency drug box of the Box of the Box" revealed, "S for emergency drug box of the Box of the Box" revealed, "S for emergency drug box of the Box of t	tandardMedications needed are kept securein the x"  essee Pharmacy Laws 201109 "EMERGENCY AND" (page 210) documented " kit shall be provided sealed cured by authorized personnel established policies"  #1 on March 19, 2012, at forth Hall Medication Room, gency box was unlocked, and ot secured per facility's policy. harmacy Consultant, by n 20, 2012, at 3:00 p.m., in Office confirmed emergency ured at all times per facility's  First Dose Blue IV Emergency on Room, with LPN #1 as unlocked. Further st of contents on the outside 23 bags of IV fluids requiring are available for emergency the list included Dextrose 5% liffiters (ml) and Normal Satine y's policy, "Emergency Drug tandardMedications needed are kept securein the	F 431	What measures will be put in systematic changes you will rethat the deficient practice does.  On 03/20/12, licensed muserviced by the director of importance of following procedure of ensuring emarc locked and secure.  b) On 03/20/12, licensed muserviced on the important the policy and procedure "Release of "Responsibil Medication" form is composed a resident's leave of at facility by the staff development coordinator.  d) On 04/18/12 and on 04/20 murses will be in-serviced development coordinator emergency boxes are lock and on ensuring the "Release of absence.  e) The director of nursing and director of nursing will au MARS/TARS to ensure the leave of absence that need done in accordance with I Center's policy and proced weeks and monthly for 1 The director of nursing will au boxes to ensure they are kneeding for 4 weeks and months.	nake to ensure s not recur: ses were in- f nursing on the he policy and ergency boxes  ses were in- e of following of ensuring the ty for oleted at the time sence from the expensive of the staff on ensuring ed and secure use of tion" form is resident's leave d/or assistant dit at residents on a medication are ife Care dures weekly for months. d/or assistant dit emergency ocked and secure	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU	-	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	
		445302	B. Wil	NG		03/21	/2012
	ROVIDER OR SUPPLIER RECENTER OF ELIZA	ABETHTON		10	REEY ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	HOME CARE KITS The emergency kit electronically secur accordance with es Interview with LPN 10:55 a.m., in the N confirmed the emer the contents were r Interview with the F telephone, on Marc the Administrator's boxes are to be security.  South/West Halls N Observation of the Box CE 08 on Marc the South/West Halls N Observation of the I of the box revealed requiring physician emergency use for antibiotic medication for blood pressure medications (Queti (Glipizide); and blo (Warfarin). Review of the facili Box" revealed, " for emergency care emergency drug be	I09 "EMERGENCY AND " (page 210) revealed "(3) shall be provided sealed or ed by authorized personnel in tablished policies"  #1 on March 19, 2012, at lorth Hall Medication Room, rgency box was unlocked, and not secured per facility's policy.  Pharmacy Consultant, by th 20, 2012, at 3:00 p.m., in Office, confirmed emergency cured at all times per facility's  Medication Room  First Dose Orange Emergency th 20, 2012, at 8:55 a.m., in ils Medication Room, with LPN ix was unlocked. Further ist of contents on the outside is 906 units of 151 medications orders were available for residents. The list included ins (Amoxicillin); medications (Atenolol); antipsychotic apine); diabetic medications od thinner medications  ty's policy, "Emergency Drug StandardMedications needed are kept securein the	F	431	How the corrective actions will be to ensure the deficient practice will i.e., what quality assurance program put into place:  a) The director of nursing and/or director of nursing will report of the emergency box audits at completion of the "Release of Responsibility for Medication" audits to the performance improvement will review the results; and if directors are the executive director of many be evaluated/revised and/or reviewed for 3 months or until compliance is achieved.  d) Performance improvement commembers are the executive director of the assistant director of nursing coordinator, the PPS nurse, the services manager, the social services manager, the social services office manager, the housekeeping supervisor, the state development coordinator, and to care nurse.	assistant the results and the form tovement to committee defined ditional the process or the audits 100% amittee for the Auditional form the movement to committee definitional the process or the audits 100% amittee for the formation of the form	5/5/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			COMPLETED	
		445302	B. Wil	VG		03/2	1/2012
	ROVIDER OR SUPPLIER RE CENTER OF ELI			16	EET ADDRESS, CITY, STAYE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 431	HOME CARE KIT The emergency k electronically sec accordance with a Interview with LP a.m., in the South confirmed the em the contents were Interview with the telephone, on Ma the Administrator boxes are to be a policy. Controlled Substa Absence Medical record re PATIENT'S CON RECORD" for All tablet for Reside 1:25 p.m., at the LPN #6 revealed tablets were sign Family" on March #3. Alprazolam in medication presor revealed the abs RESPONSIBILIT documenting the for the leave of a received by a far	A09 "EMERGENCY AND "S" (page 210) revealed "(3) it shall be provided sealed or ured by authorized personnel in established policies"  N #2 on March 20, 2012, at 8:56 NWest Halls Medication Room, bergency box was unlocked, and e not secured per facility's policy.  Pharmacy Consultant, by surch 20, 2012, at 3:00 p.m., in so office confirmed emergency secured at all times per facility's ance Medications for Leave of eview of the "INDIVIDUAL ITROLLED SUBSTANCES prazolam 0.25 milligram (mg) at #21 on March 19, 2012, at North 2 Medication Cart with three Alprazolam 0.25 mg ed out as "Sent home with 17, 2012, at 11 a.m., by LPN (Xanax) is a controlled substance wribed for anxiety. Further review ence of a "RELEASE OF" Y FOR MEDICATION" form three Alprazolam 0.25mg tablets absence were signed out as		431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445302	B. WIN	IG_		03/2	1/2012
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ELIZABETHTON				10	REET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LLZABETHTON, TN 37643		
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 431	dated by the physic revealed an order for TABLETTAKE 1 THREE TIMES DAI Medical record revior OF RESPONSIBILI ABSENCE" form re #21 signed Resider March 17, 2012, at Resident #21 to the 2:45 p.m.  Interview with the L 1:30 p.m., at the No North Hall Nursing of a "RELEASE OF MEDICATION" form Alprazolam 0.25mg absence were signed member.  Interview with the Ir (DON) and the Administrator in the medical record Alprazolam 0.25mg received by a family policy for a leave of interview with LPN administrator, on M the Administrator, on M the Administrator's Alprazolam 0.25 mg	ian on March 6, 2012, or "ALPRAZOLAM 0.25MG TAB (tablet) BY MOUTH	F	131	DEFICIENCY		
į		used to the brother of Resident learning as sumentation of a signature of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		445302	B. WING		03/21/2012			
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ELIZABETHTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E ELIZABETHTON, TN 37643					
(X4) ID PREFIX TAG	I (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		IULD BE	(X6) CONPLETION DAYE	
F 441 SS=E	"RELEASE OF REMEDICATION" for leave of absence to it.  483.65 INFECTIONS PREAD, LINENS  The facility must element in the facility must en disease and infection Control Fafe, sanitary and to help prevent the of disease and infection Control Facility must en disease and infection Control Facility must en disease and infection Control Facility must en disease and infection the facility;  (2) Decides what should be applied (3) Maintains a reactions related to (b) Preventing Sp.  (1) When the Infection Control Facility must encommunicable dispection direct contact will (3) The facility must encommunicable dispection direct contact will (3) The facility must encommunicable dispection direct contact will (3) The facility must encommunicable dispection direct contact will (3) The facility must encommunicable dispection direct contact will (3) The facility must encommunicable dispection direct contact will (3) The facility must encommunicable dispection direct contact will (3) The facility must encomplete the resident direct contact will (3) The facility must encomplete the resident direct contact will (3) The facility must encomplete the resident direct contact will (3) The facility must encomplete the resident direct contact will (3) The facility must encomplete the resident direct contact will (4) The facility must encomplete the resident direct contact will be direct contact will the resident direct contact will be direct contact	B was aware of the facility's SPONSIBILITY FOR m and the facility's policy for out "completely forgot" to follow N CONTROL, PREVENT stablish and maintain an program designed to provide a comfortable environment and edevelopment and transmission ection.  Tol Program establish an Infection Control nich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections.  Tread of Infection ction Control Program resident needs isolation to dof infection, the facility must not. Its prohibit employees with a sease or infected skin lesions of with residents or their food, if transmit the disease. Its trequire staff to wash their direct resident contact for which ndicated by accepted		441	What corrective actions will be acc For those residents found to have be affected by the deficient practice:  a) On 3/19/12, resident #1's cather changed by the charge nurse.  b) On 03/19/12, licensed nurses a nursing assistants were in-servimportance of ensuring a safe, and comfortable environment prevent transmission of diseas infection related to catheter castaff development coordinator.  Flow you will identify other reside the potential to be affected by the adeficient practice and what correct will be taken:  a) Residents with catheters have to be affected by this deficient by On 03/19/12, nursing administ reviewed all residents with catheters with catheters were being approprimanaged to prevent the transmission.  What measures will be put into playstematic changes you will make that the deficient practice does not a) On 03/19/12, licensed nurses nursing assistants were in-ser importance of ensuring a safe and comfortable environment prevent transmission of diseas infection related to catheter of staff development coordinate staff development coordinate.	een ster bag was and certified riced on the sanitary, to help e and re by the same ive action the potential t practice. tration theters to antionately mission of ace or what to ensure trecur, and certified viced on the sanitary, to help see and care by the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLEYED	
		445302	B. WING	3	03/21	/2012
	ROVIDER OR SUPPLIEF	•		STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E ELIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EAGH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		HQULD BE	(X6) COMPLETION DATE
F 441	(c) Linens Personnel must h transport linens s infection.  This REQUIREM by: Based on medic and interview, the control strategies catheter for one r residents reviewe The findings inclu Resident #1 was December 12, 20 Dementia, Osteo Failure, Psychos Medical record re dated February 2 Cath (Catheter) (Methicillin Resis urine."  Observation on I the resident's roo bed with a urinar Continued obser	eandle, store, process and o as to prevent the spread of ENT is not met as evidenced al record review, observation a facility failed to ensure infection were maintained for a urinary resident (#1) of twenty-five ed.  admitted to the facility on 208, with diagnoses including approsis, Congestive Heart	F 44	b) On 04/18/12 and on 04/20/1 nurses will be in-serviced by development coordinator on safe, sanitary, and comfortal environment to help prevent of disease and infection relacare by the staff development.  The director of nursing and director of nursing will audit with catheters/infection comprocedures throughout the for 4 weeks and monthly for How the corrective actions will to ensure the deficient practice with the interpretation of the catheter/infection contained audits to the performance in committee for three months.  The performance improvem will review the results; and necessary by the committee education may be provided may be evaluated/revised at reviewed for 3 months or accompliance is achieved.  C) Performance improvement members are the executive medical director, the director of nurse, services manager, the social director, the dietary manager.	the staff ensuring a  alle transmission ted to catheter at coordinator. or assistant tresidents acility weekly a months. the monitored till not recur; the results are procedure approvement the results are procedure approvement the process and/or the audits atil 100% committee director, the or of nursing, sing, the MDS the rehab l services or, the	
	March 19, 2012,	censed Practical Nurse #4 on at 10:59 a.m., in the resident's the exit port of the catheter was ar and the facility had failed to		pharmacist, the maintenanc business office manager, th housekeeping supervisor, the development coordinator, a care nurse.	e staff	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED			
445302		8. WING		03/2	03/21/2012				
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ELIZABETHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E ELIZABETHTON, TN 37643					
(X4) ID PREFIX TAG -	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IÓ PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 441	Continued From pa maintain infection of source of infection.	control strategies to prevent a	F 44						

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